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Nurse Practitioners' Attitudes Toward Geriatric Euthanasia

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NURSE PRACTITIONERS' ATTITUDES TOWARD GERIATRIC EUTHANASIA

by

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To My Father

Joe Villarrubia

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Abstract

Health care professionals are being confronted with dilemmas about when and if life should be prolonged for the elder. This situation has been intensified because of the development of technology and the aging of the population. The purpose of this descriptive study was to examine nurse practitioners' attitudes toward geriatric euthanasia. Travelbee's Human-to-Human Relationship Model was the theoretical framework for this research. A sample of 47 nurse practitioners in Mississippi who had the probability of caring for the elder participated in this study. Nurse practitioners were asked to complete the Thompson Life-Prolonging Survey in which vignettes describing geriatric patients were presented that required a decision to either endorse or not endorse passive euthanasia. Subjects were asked to agree or disagree with the decision made in the vignettes and also to comment on their responses. Results indicated that of the 187 responses to passive euthanasia/pro-life decisions, 108 (58%) of the nurse practitioners' choices endorsed passive euthanasia for the elder patient, while 79 (42%) of the nurse practitioners' responses endorsed pro-life. Six common themes were

identified in the comment section: patient/family wishes, poor quality of life, sanctity of life, death with dignity, scarce resources, and ethics. Based on these findings, the researcher concluded that nurse practitioners' attitudes about euthanasia in the elder patient have not been clearly identified. Results indicate that nursing as a profession needs to address the problems involved with euthanasia. Education about euthanasia will help nurse practitioners, patients, families, and significant others to develop informed attitudes about geriatric euthanasia. Implementation of educational programs about euthanasia and ethical decision-making skills will help nurse practitioners to determine attitudes. Recommendations for further study included the conduction of other research to identify nurse practitioners' attitudes on geriatric euthanasia using another questionnaire in which patient/family wishes were known.

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Chapter I

The Research Problem

Euthanasia has become one of the most controversial issues in modern health care. Advancing medical technology has provided the means to prolong life, but the aging population has created dilemmas about if and when life should be sustained. Nurse practitioners are becoming aware of this problem because they are involved in patient care and because of their role as patient advocates. They have the responsibility to provide state-of-the-art health care, but also realize this duty may place an undue burden on the elderly client and family members. Nurse practitioners are aware of the need for intervention on the elder's behalf (Travelbee, 1971) and realize the dilemma involved when the technological ability to sustain life confronts an elder's right to self-determination. In spite of this dilemma, few studies have examined nurse practitioners' attitudes toward geriatric euthanasia. Therefore, the purpose of this study was to further identify these attitudes.

Introduction to the Problem

The health care system in the United States has become almost synonymous with technology due to numerous

technological breakthroughs in medical science. Biomedical developments have made it possible to retard or reverse conditions that were at one time considered terminal. Patients are being kept alive through technology, with little possibility for returning function or improving quality of life. The goal of medicine would appear to be moving toward quantity, rather than quality of life (Johnson & Weiler, 1990). This viewpoint was addressed by Heaney (1990) who stated, "The purpose of medicine is not the preservation of life, but the maintenance and restoration of health, of functioning capacity" (p. 303).

In spite of advancing life-sustaining technology and apparent goal changes for medicine, one goal of nursing has remained constant. Nursing is still focused on caring for the patient; nursing's purpose remains "high touch" in the "high tech" world of medicine (Webster, 1988, p. 49). In the last few decades as technology developed, nursing became more autonomous and assumed an expanded role as primary care-givers. However, nurses and nurse practitioners continue to be the health care providers who provide comfort and support to patients. Nurses realize that even while they cannot cure, they can care. Caring, for nurse practitioners, as primary care providers, includes improving a patient's quality of life (Rhymes, 1991).

As health care is being altered by technological advances in medicine and role changes in nursing, the aging

of the American is also impacting contemporary health care. The population of the United States is growing older and living longer, and life expectancy is increasing. By 2030, 64.6 million or 21.2% of the population will be over age 65. This figure represents a 250% increase over what it was in 1980. The older population itself is aging. In 1986, the 65-74 age group (17.3 million) was eight times larger than it was in 1900, but the 75-84 group (9.1 million) was 12 times larger and the 85 and above group was 22 times larger. The fastest growing segment of the elderly population is those 85 and above. This segment is expected to triple in size between 1980 and 2020 (Matheson, 1990).

With the aging of the population comes an increase in health care needs. The elderly are much more likely to suffer from a chronic disease than the young. Eighty percent of older Americans have one or more chronic conditions, with nearly half of the aged unable to perform some activity of daily living (Ebersole & Hess, 1990).

As a result of an increasing elder population and because modern technology is able to prolong life, health care professionals are facing problems about when and if life should be prolonged. Nurse practitioners are health care professionals who are intensely involved with elder clients and who develop relationships which allow opportunity for consultation on life and death situations. This unique situation demands that nurse practitioners

affirm a position on the euthanasia issue (Johnson & Weiler, 1990).

Callahan (1987) commented on whether life should be prolonged, "The existence of medical technologies capable of extending the lives of the elderly who have lived out a natural life span creates no presumption whatever that the technologies must be used for that purpose" (p. 25). Euthanasia may help deal with this problem and is basically defined as the act or practice of inducing a quiet and early death (Davis & Slater, 1989). Euthanasia is literally thought of as a "good death"; however, several distinctions are made in explaining euthanasia. McCuen and Boucher (1985) presented four categories commonly used when discussing euthanasia: active, passive, voluntary, and nonvoluntary.

> 1. Active euthanasia is the inducement of death solely by means without which life would continue naturally.
>
> 2. Passive euthanasia is the inducement of death by the nonuse or withdrawal of treatment necessary to sustain life.
>
> 3. Nonvoluntary euthanasia is euthanasia administered to a person without his consent.
>
> 4. Voluntary euthanasia is the ending of a person's life at his request when he suffers from an incurable disease or disability. (pp. 49-51)

In this research, euthanasia was viewed as a passive and voluntary act that allows patients to die with as little suffering as possible.

Nurse practitioners approach euthanasia with moral and ethical concerns. One such moral concern is the patient's right to choose medical interventions that will impact on his life and his manner of dying. This choice creates the dilemma of quality of life versus quantity of life and extension of life versus prolongation of death (Ebersole & Hess, 1990). Nurse practitioners have the responsibility to educate the patient about his options for care in light of current technologies. Moreover, nurse practitioners have the responsibility to honor the patient's desires to continue or stop treatment. But, the practice of euthanasia creates problems about the morality of killing, the duties of physicians and health care providers, and the impact on families. The legal system still considers euthanasia as suicide or murder, and some churches believe that it violates human life. Ethical problems are encountered by nurse practitioners when the use of technology prolongs a patient's dying or withdrawal of technology allows the patient's death (Degner, 1974).

Euthanasia also arouses questions about the duties of physicians and other health care providers. These providers determine the treatment necessary for patients. Decisions for treatment may be affected by legal factors that dictate a certain standard of care. The initiation of some measures of care may be mandated by medico-legal considerations, and

the withholding or withdrawing of these measures may have legal implications (Wanzler et al., 1984).

The practice of euthanasia affects families and loved ones. When treatments and modalities of care are withheld or withdrawn, families' hopes for recovery also may be removed. Families may resist euthanasia because they feel threatened, overwhelmed, or at a loss to know how to respond (Degner & Beaton, 1987).

Euthanasia de-emphasizes scientific advancements and reestablishes the patient as the person responsible for decisions concerning life and death (Larue, 1989). Thus, euthanasia has been seen as a logical extension of the individual's right to decide what is done to his or her own person. However, the withholding or withdrawing of treatment may affect families and loved ones leaving them hopeless and overwhelmed. The practice of euthanasia may not be morally acceptable and may create legal problems and create problems for nurse practitioners.

Significance to Nursing

Euthanasia has become a serious decision-making dilemma for contemporary health care providers. In a study by Brown, Thompson, Bulger, and Laws (1971), nurses were found to have heard more requests for euthanasia than physicians, and nurses with master's degrees heard more requests for active euthanasia. By determining nurse practitioners' attitudes toward euthanasia, this current research helped to

define the nurse practitioner's role in euthanasia. Nurse practitioners who participated in this study stated their opinion on this controversial issue and made a choice in the right-to-die debate.

Many nurses feel uncomfortable caring for clients who are dying (Kelly & Yetman, 1987). This research made nurse practitioners who responded confront this discomfort and provoked a realization of another dimension to the role of advocate in the primary care role.

According to Travelbee (1971), nursing's primary function is to help patients cope with and find meaning in their suffering. The patient is assisted in this manner through the role of advocate. The patient is constantly confronted with choices and conflicts. Conflict is not to be shunned but rather appreciated for its ability to present choices. These choices are constantly referred to in this study by the respondents as "patient's wishes." Frequent references to the patient's and family's wishes emphasize the nurse practitioner's role of advocate in euthanasia decisions.

In studying a death and dying issue, this research also helped to determine nurse practitioners' knowledge about the euthanasia concept. This study established the need for education to nurses in the expanded role about "death with dignity." Also, since this study examined a contemporary health care issue and determined nurse practitioner

attitudes toward geriatric euthanasia, the information obtained may provide data for input into government policy, legislative debates, and curriculum revisions.

Theoretical Framework

Travelbee's Human-to-Human Relationship Model provided the theoretical framework for this research. According to this model, nursing's purpose is "to assist the individual to prevent or cope with the experience of illness and suffering and if necessary find meaning in these experiences" (Travelbee, 1971, p. 7). In this model, nursing's purpose is achieved through the interaction of many factors or concepts. Of particular interest to this study were the concepts of nurse, individual, rapport, and suffering as adapted from Travelbee (1971).

Travelbee (1971) defined the nurse as a human being who possesses specific knowledge and who uses this knowledge and herself to intervene, assist the individual with coping with illness, and find meaning in these experiences. The individual is considered a human being who is constantly confronted by choices and is consistently burdened by choosing and deciding. The individual also realizes that inherent in the act of choosing is the responsibility for these choices.

Travelbee (1971) believed suffering was as much a part of the human condition as choice. Suffering is intrinsic to the human condition and is a "condition which varies in

intensity, duration, and depth" (p. 62). Suffering has both physical and mental components. Suffering is not restricted to physical pain, but includes mental anguish as well. Nurses need to understand the patient's experience of suffering by eliciting from the patient his perceptions of his problems.

Patient perceptions can be gleaned through establishing rapport. Rapport, relatedness, and human-to-human relationship are all terms used interchangeably by Travelbee (1971) to express the relationship that evolves between the nurse and the patient. This relationship is the means through which nurses assist patients to cope with and find meaning in their illness.

In this study, as in Travelbee's model, the nurse practitioner has knowledge, ability, and responsibility to intervene and support the elder patient as advocate. The nurse practitioner possesses attitudes toward euthanasia that will affect the ability to intervene, find meaning, and act as advocate for the patient.

This researcher believed the patient to be burdened with choices and decisions about manner of living and dying. The elder patient who is dying may be faced with decisions involving euthanasia. Suffering, as in Travelbee's model, is both the physical discomfort felt by the dying patient and the mental anguish endured as the process of dying is faced and decisions are made that impact on death. Rapport

is viewed in this study, as in Travelbee's model, as a reciprocal process by which the patient can make wishes known and the nurse practitioner can intervene to help the patient find meaning. Rapport is the means the nurse practitioner uses to help the patient cope and find meaning in suffering. In this study, the nurse practitioner may have realized that rapport can help the patient make decisions about euthanasia and is a way of supporting the patient after the decision to accept euthanasia is made. According to Travelbee (1971), the purpose of nursing is to assist the patient in coping with illness, suffering, and dying and find meaning in these experiences. Euthanasia in its simplest form is a means of coping and finding meaning. It is a way of confronting illness, suffering, and dying by allowing the patient to be as comfortable as possible, as in control as possible, and as pain free as possible (Thorson & Powell, 1990).

Assumptions

This study had the following underlying beliefs:

1. Euthanasia is a moral and ethical dilemma.

2. Nurse practitioners have developed attitudes toward geriatric euthanasia.

3. Attitudes can be measured through a self-report questionnaire.

4. A nurse practitioner's attitudes about illness and suffering will determine the extent to which dying elders

can be helped to find meaning in these situations (Travelbee, 1971).

Statement of the Problem

Nursing as a health care profession is involved in the moral and ethical dilemmas that euthanasia evokes. Nurse practitioners realize that as members of a caring profession they are expected to preserve or prolong the life of any patient in their care (Winget, Kapp, & Yeaworth, 1977). However, nurse practitioners may also realize their role is to be responsive to the patient's desires and to support these desires. Nurse practitioners also feel a strong reverence for life that drives them to do everything possible to prolong life (Anderson, 1988); yet, no research has explored nurse practitioners' positions toward euthanasia. Therefore, the problem to be investigated was what attitudes do nurse practitioners hold regarding euthanasia in the elder.

Research Question

The research question which guided this study was what are nurse practitioners' attitudes toward geriatric euthanasia?

Definition of Terms

For this study, terms were defined as follows:

Nurse practitioner. Theoretical Definition: Any registered nurse who is prepared to deliver primary care

through a formal organized educational program that meets established guidelines determined by the profession (American Nurses' Association, 1985). Operational Definition: Any nurse practitioner (family, adult, or obstetrical-gynecological) who is certified and practicing in the state of Mississippi.

Attitudes. Theoretical Definition: "Beliefs with affective, cognitive, and behavioral dimensions. [An attitude] is an integral part of how individuals think and feel about death and ultimately how they will behave when faced with death" (Bandman & Bandman, 1985, p. 261). Operational Definition: Attitudes toward euthanasia as determined by the Thompson Life-Prolonging Survey.

Geriatric euthanasia: Theoretical Definition: A passive, voluntary act, in which death is induced by the nonuse or withdrawal of treatment necessary to sustain life at the request of the patient who is suffering from an incurable disease or disability. Operational Definition: The means of inducing death to a patient 55 years or older by withholding or withdrawing treatments as described in the Thompson Life-Prolonging Survey.

Chapter II

Review of the Literature

Even though euthanasia is a problem in contemporary health care, it is not a new problem. Euthanasia has been discussed in the literature for years. When technology developed to such a point that it could extend life, research began to investigate attitudes, beliefs, and decisions about euthanasia. Research about euthanasia was more prevalent in the 1970s but has since become scant. Euthanasia has reentered society's consciousness because the continual introduction of new technologies make a natural death increasingly difficult to attain. A review of the literature revealed few recent studies; however, there were several studies that reported conclusions relevant to this study.

Degner (1974) designed a study to test a sociological scale that would elicit physician's tendencies in regard to life-prolonging decisions; and secondly, to determine if significant differences existed in physicians' tendencies regarding life-prolonging decisions on the basis of the beliefs they held. The specific beliefs selected for investigation were beliefs concerning God, afterlife, and death. Advances in medical technology were just beginning

to intensify the conflict between the traditional medical goals of prolonging life and preventing suffering. The study by Degner had an exploratory design and used a survey approach with a questionnaire. The questionnaire included a scale designed to measure life-prolonging decisions, questions about belief in God and afterlife as developed by Glock and Stark, and a semantic differential for the concept of death as developed by Folta. The sample consisted of 92 staff members of a 300-bed nonsectarian hospital in an urban area of the northwestern United States. The respondents were all male; the few female physicians on staff in 1974 opted not to respond to the questionnaire. The scale presented four vignettes in which the respondents were asked to agree or disagree with a decision to sustain life on a Guttman scale. Respondents were then classified as prolongers or non-prolongers. The questions used to determine belief in God and afterlife were not discussed; however, the Folta semantic differential of death was discussed in detail. Death was found to be factored by evaluative, commonness, control, emotionality, and tempo.

Degner (1974) classified the majority of physician-respondents as non-prolongers. The great majority (79%) of the 92 physicians in the sample favored withdrawing treatment from terminally ill patients in at least two out of three imaginary situations. A comparison of the sample's life-prolonging decisions by their beliefs in God and

afterlife yielded no significant differences, but responses to the religious questions of belief in God and afterlife revealed an interesting paradox. The majority of physicians expressed belief in God but professed not to believe in an afterlife. The results of the factor analysis of death found by Degner (1974) were correlated to life-prolonging decisions. The data indicated that the greatest number of physicians classified as non-prolongers viewed death as a neutral or negative phenomenon. Only 5 of 63 respondents classed as non-prolongers viewed death in a positive way. This finding is significant if the concept "death" is considered to include the notion of the dying process. The physician who viewed dying negatively would not want to prolong the process. These conclusions help to support the need for this current study. Insofar as life-prolonging situations create a conflict in health care, exploration of the attitudes of health care providers such as nurse practitioners about geriatric euthanasia can provide information about these conflicts.

In an earlier study by Brown, Thompson, Bulger, and Laws (1971), nurses' experiences were compared to physicians' experiences about requests for euthanasia and abortion and whether nurses would cooperate in the implementation of euthanasia and abortion if social mores permitted. Data were collected from nurses using a questionnaire which closely paralleled one distributed to

physicians the prior year. The questionnaire included three groups of questions. The first assessed nurses' experiences with requests from terminally ill patients and their family members for passive euthanasia. A second group of questions investigated respondents' attitudes toward physicians' practice of passive or active euthanasia, statements of authorization by the patient or his family, and formation of a health board to consult with physicians on life and death decisions. A third group of questions explored attitudes toward abortion under various circumstances.

The questionnaire was sent to each registered nurse and licensed practical nurse at two hospitals, one a large university-based hospital and one a large community hospital. A total of 687 nurses responded from all specialities including psychiatry and administration. The study by Brown et al. (1971) discovered that more nurses than doctors heard requests from patients for euthanasia. A unique finding was that more nurses with Master's degrees reported having heard family requests for active euthanasia than did practical nurses, and nurses in administration and "floaters" heard the largest number of requests for negative euthanasia. The researchers speculated that requests for euthanasia came, paradoxically, when the nurse was less emotionally involved with the patient, and that it may be easier for the patient to volunteer concern for death to

those who have little direct responsibility for either his death or its prevention.

Sixty-eight percent of nurses reported being uncomfortable when the physician was not practicing passive euthanasia than when he was, and 85% said they would practice passive euthanasia with a signed statement of consent. By comparison with physicians, nurses showed more desire for changes in social customs to allow euthanasia. The authors of this study interpreted this result by commenting that the nurse faces her patient every day and feels the helplessness of the situation and realizes the inappropriateness of the physician's orders. According to Brown et al. (1971), endorsing the hastening of death may help the nurse to relieve herself from the emotional strain of facing the dying patient.

The second set of questions regarding the establishment of a health board to help make life-death decisions showed more support from the nurses than from the physicians (77% versus 51%). The researchers again speculated that nurses support for a health board may stem from the traditional role of the nurse "to follow orders." Questions on abortion revealed nurses and female physicians favored abortion less than male physicians under all circumstances except by decision of a health board. Marked variation was present though across specialty groups.

The study by Brown et al. (1971) lends support for the need for this current study. Nurse practitioners are in the position to see the patient's loss of autonomy, to question the necessity of services, and to establish the patient's need for advocacy (Hayne, Moore, & Osborne, 1990). This current study helped to identify the nurse practitioner's role in the care of the dying patient and explored nurse practitioners' attitudes toward euthanasia.

A study by Winget et al. (1977) sought to identify the attitudes toward euthanasia held by medical, nursing, general college students, practicing physicians, and nurses which stimulate conflict. They conceptualized the conflict by classifying these problems into either interpersonal or intrapersonal areas. Data were collected using a questionnaire developed by an interdisciplinary research group at the University of Chicago. The questionnaire contained five items specific to euthanasia. These five items each addressed a certain aspect of the dilemma of euthanasia. The questionnaire had a 5-point Likert scale for responses ranging from strongly agree to strongly disagree. The first statement introduced variables (e.g., age, disabilities, and patient's wishes) that may influence a health professional's attitude; the second questioned attitudes toward active and passive euthanasia; the third identified role expectations; the fourth addressed philosophical responses; and the fifth questioned attitudes

toward euthanasia directly. The three questions that identified euthanasia specifically resulted in a 88-96% agreement with euthanasia. The statement that provided variables that may influence attitudes showed an overall increase in all groups in indecisiveness and a decrease in the percentages agreeing to euthanasia. The statement that evoked role expectations resulted in an overall decrease in the agreement with euthanasia. The statement that endorsed active as well as passive euthanasia showed an increase in indecisiveness. Winget et al. concluded that inconsistency in attitudes toward euthanasia was related to role perceptions versus personal beliefs or interpersonal problems.

Interpersonal attitudinal problems occur when health care providers' attitudes are in conflict with role expectations. With regard to this current study, nurse practitioners may feel the patient has the right to choose regarding life and death matters and may be willing to support him or her, but in their role as primary care providers they also may feel a reverence for life and may feel obliged to preserve or prolong life. This current study determined the attitudes of nurse practitioners toward geriatric euthanasia and examined the difficulties or conflict experienced with these attitudes.

Attitudes and beliefs about euthanasia were further studied by Davis and Slater (1989). The purpose of this

study was to identify the possible discrepancies that nurses would perceive between what treatment actually would be done and what treatment nurses thought should be done for terminally ill patients. In addition, the study examined the differences and similarities between United States and Australian nurses' attitudes toward euthanasia.

Davis and Slater (1989) examined 32 United States nurses and 32 Australian nurses and presented them with vignettes in which the patient was likely to die. The vignettes were presented in interview format, and the participants were asked what they thought was usually done in that type of situation and what they thought should be done. Participants were questioned in detail about their responses to understand the ethical justification to the answers. The study found the two groups of nurses agreed on only three of the eight vignettes. The United States nurses wanted to involve the family more in decision making, were more ambivalent to withholding food and fluid, and emphasized the nurse's role of advocate. The lack of agreement between the American and Australian nurses on issues of euthanasia was felt to be based on several factors: the differences in the health care system, the general social position of nursing as a profession, the relationship among health professionals, patients and families, and the role of the law in health care decisions. However, an important finding of Davis and Slater is that

neither group of nurses used age as a criterion for withdrawal of life support from patients. The responses to the vignette that described an active independent 80-year-old woman who was depressed and wanted to die were in agreement that she would not and should not be allowed to die. These responses were linked more to the prognosis and the fact that the woman did not want to live because of her diminished quality of life than to her age. No specific recommendations were made in this study, but Davis and Slater believed that health professionals have an obligation to examine these issues and develop "a reasoned ethical position" (Davis & Slater, 1989).

The present study sought to examine nurse practitioners' attitudes toward what should be done in cases of geriatric euthanasia. In responding to the questionnaire, nurse practitioners had to make a choice on this ethical problem and began to develop an awareness of the dilemmas that they confront.

The impact of work experience on anticipated response to situations involving death and dying in a hospital were studied by Stoller (1980). The research was a nonexperimental quantitative design based on the results of 62 questionnaires completed by registered nurses (RNs) and licensed practical nurses (LPNs) in a New York hospital. The questionnaire was composed of four sections. The first focused on response of the nurse to death-related issues,

and the other three examined work experience and age and death-related fears. Findings indicated that the LPN developed coping mechanisms to alleviate the uneasiness associated with nursing the dying, but RNs did not increase in ability to cope; ironically, the uneasiness increased. Stoller concluded that this inconsistency might be related to the RN's job structure which may be far removed from hands-on care so that there is minimal contact with the dying. Stoller recommended further study to explore the effect of experience on uneasiness associated with interaction with dying patients. This researcher's study looked at the effect of experience on response to dying and death as it was related to nurse practitioners' attitudes on euthanasia. Nurse practitioners as primary care-givers will confront the issues of death and patients who are dying. However, the nurse practitioner's more direct experience with patients who are dying should make them more aware of the dying patient's wishes.

The relationship between the multidimensional elements of fear of death and dying and a unidimensional construct of intrinsic religiosity were examined by Thorson and Powell (1990). This descriptive correlational study hypothesized that both age and religiosity would have significant negative relationships with elements of death anxiety. The study had a large sample composed of members of a chapter of the American Association of Retired Persons, a civic

organization, a continuing education program, and college students. The instruments used were Hoge's Intrinsic Religious Motivation Scale (IRM) and the measure of death anxiety.

The researchers found that both age and religiosity associated negatively with death concerns. The respondents who were lower in religiosity were highest in death anxiety. The separate factor analysis indicated people high in internal religiosity did not construe death and dying much differently. Groups both high and low on death anxiety had fears associated with the process of dying, not death itself. Older respondents were significantly lower on the death anxiety scale and higher on the internal religious motivating scale.

However, what is important to this researcher's study on geriatric euthanasia is Thorson and Powell's (1990) examination of death anxiety. Even though intrinsic religiosity may have altered death anxiety, all groups questioned still seemed to fear dying more than they feared being dead. The fear of the process of dying, the discomfort, the helplessness, and the pain were found in all groups. The respondents in Thorson and Powell's study all had immediate concerns of being kept comfortable, pain free, and in control. These factors are, in essence, the determinants for the acceptance of euthanasia. This researcher's study also surveyed the attitudes and the

acceptance of euthanasia by examining the nurse practitioners' answers on the Thompson Life-Prolonging Survey.

Wetle, Cwikel, and Levkoff (1988) studied factors influencing allocation of scarce resources and the decision to withhold treatment in geriatric situations. The study examined 248 physicians, nurses, and social workers by presenting them with two vignettes. One vignette examined allocation of scarce resources by having respondents specify between a 75-year-old and a 35-year-old (who both were cognitively and functionally equivalent) who should get the last available Intensive Care Unit (ICU) bed. The other involved a decision to withhold treatment by describing an elderly patient whose health status and prognosis were quite poor. Respondents were asked if they would support intubation in this patient with acute respiratory failure.

The participants were asked about their actual decisions in the vignettes and about factors that influenced these decisions. A variety of medical, social, and institutional factors, as well as characteristics of the patient, were identified as factors influencing the decisions. The principal interest of this study was to examine the importance of factors that influenced clinical decisions.

Wetle et al. (1988) concluded that medical risk was more important in decisions to allocate scarce resources,

and expected quality of life was the main factor in withholding treatment to intubate the patient. The researchers went to great lengths to explore different models which were established in the study as predictors of the outcomes of decision making. The significant relationship between Wetle et al.'s (1988) research and this researcher's study was that quality of life considerations were more often used to support decisions to withhold therapy than to use a life-sustaining therapy. Furthermore, decision making based on evaluations of quality of life is biased against the elder since the prevalence of chronic illness in late life implies that fewer quality years remain.

Wetle et al. (1988) recommended further research on relationships among decision making, withholding treatment, and age. This present study explored attitudes toward geriatric euthanasia, which is an issue involving these three factors. This researcher's study described the nurse practitioner's feelings toward life-prolonging treatments.

The review of the literature disclosed information that was pertinent to this researcher's study. In the early 1970s when technology was just beginning to expand, nurses and physicians felt conflict over prolonging life (Brown et al., 1971; Degner, 1974) and role expectations were creating dilemmas about euthanasia (Winget et al., 1977). In the 1990s, expanding technology is being used to extend life,

and health care professionals are involved in more complex decisions about the right to die, with some professionals publicly proclaiming their participation in euthanasia. The interaction of experience on decisions (Stoller, 1980) and the effect of age as a factor in attitudes toward euthanasia (Davis & Slater, 1989; Wetle et al., 1988) were components of this study. The fear of dying as opposed to the fear of being dead (Thorson & Powell, 1990) may have influenced respondents' attitudes toward euthanasia. This present study synthesized ideas from all of these studies by describing, defining, and exploring nurse practitioners' attitudes toward geriatric euthanasia. This research has helped to establish the role nurse practitioners may assume when caring for a dying patient.

Chapter III

The Method

The purpose of this descriptive study was to determine nurse practitioners' attitudes toward geriatric euthanasia. Descriptive studies have as their main objective the accurate portrayal of characteristics of persons. The main purpose is to "observe, describe and document aspects of a situation" (Polit & Hungler, 1987, p. 143). This descriptive study sought to examine attitudes of nurse practitioners toward geriatric euthanasia. The variables of interest were nurse practitioners' attitudes and geriatric euthanasia.

Setting, Population, and Sample

The setting for this study was Mississippi, a southern state, with a majority of elders (59%) living in rural areas and representing 15% of the population in these locations (Saunders, 1987). Nurses have always been in the forefront in caring for the elderly (Ebersole & Hess, 1990), and nurse practitioners have taken on a primary care role to provide quality care to elders.

In 1989, there were 120 nurse practitioners functioning in Mississippi representing a variety of specialities such

as neonatal care, adult, pediatrics, and family care. Nurse practitioner categories selected for this study were based on probability of caring for the elder. All nurse practitioners in the categories of adult nurse practitioner, family nurse practitioners, and obstetrical-gynecological nurse practitioners were included in this study. A list of all currently licensed nurse practitioners was obtained from the State Board of Nursing. All practitioners whose names appeared on this list for these specialities were sent a questionnaire. Anonymity was assured for the subjects as no names appeared on the questionnaires. A total of 94 questionnaires were mailed, 4 were returned with insufficient address, and 48 (53%) were returned for evaluation. One questionnaire was eliminated because both the demographic survey and the vignettes were not returned. The final number of questionnaires to be evaluated in this study was 47 (52%).

Methods of Data Collection

Instrumentation. The Degner Life-Prolonging Scale was the basis for the adapted Thompson Life-Prolonging Survey. Permission was obtained from the author of the Degner Life-Prolonging Scale to adapt the instrument for this research (see Appendix A). The Degner Life-Prolonging Scale was designed in 1974 to measure attitudes toward prolonging life. The scale consisted of four vignettes describing clinical situations in which physicians make judgments to

institute, withhold, continue, or withdraw life-prolonging measures. Respondents were asked to indicate degree of agreement or disagreement. The Thompson Life-Prolonging Survey adapted the vignettes to fit geriatric patients. Only three of the Degner Scale vignettes were used. These vignettes were altered by changing ages and diagnoses to fit the elder client. Also, a fourth situation was designed that was considered usable in this study. The survey's scoring was also altered to reflect only two categories, those who agreed to passive euthanasia or those who endorsed pro-life efforts.

Scoring of the four items involved ratings of 1 and 2. On Questions 1 and 4, a 1 meant the respondent agreed with a decision not to prolong life. On Questions 2 and 3, the scores were reversed, a 1 meant the respondent agreed to prolong life.

Because patient's social value could have created a bias for respondents and affected external validity, the Thompson Life-Prolonging Survey was designed to present a balance between patient's social value and the type of decision made by the imaginary physician. Of the two situations concerning patients of negative social status, one has a decision to prolong life and the other a physician's decision not to prolong life. Similarly, the two situations about patients of positive social status contain one decision to sustain life and one not to sustain.

The reason for design of the survey in this manner was to control for the effect of social value on the respondents' decisions (Degner, 1974).

The reliability and validity of the Degner scale were established through a scalogram analysis resulting in a coefficient of reproducibility of 0.89. A coefficient scalability of 0.44 on Question 4 indicated this question was poorly correlated with the scale. A second scalogram analysis of responses to the first three vignettes yielded a coefficient of reproducibility of 0.96 and coefficient of scalability of 0.80; therefore, only the first three items were scored. The Thompson Life-Prolonging Survey does not have validity and reliability, but it closely parallels the Degner Scales, thus the Thompson Life-Prolonging Survey was assumed to have face validity.

Limitations. This study had certain restrictions on generalization. Even though all nurse practitioners in the state who cared for elderly clients were included in the sample, this number represents a limited number of nurse practitioners overall, and the nurse practitioner's experience with dying elders is uncertain. Only four respondents were male. Inaccuracies would probably occur if these findings were generalized to the entire population of male nurse practitioners or nurse practitioners overall.

The vignettes used in this research depicted specific disease entities that may have been outside the field of

expertise of some nurse practitioners, and, therefore, may have affected their responses. The vignettes used in this study also reflected acute care situations and since most nurse practitioners work in a primary care setting, these situations may have portrayed unfamiliar territory to the nurse practitioners. The Thompson Life-Prolonging Survey places another possible limitation on this research because it has no established validity and reliability.

Procedures. Approval for research was obtained from the Committee on Use of Human Subjects in Experimentation of the Mississippi University for Women (see Appendix B). A telephone call was made to the State Board of Nursing to obtain a mailing list of all nurse practitioners selected for inclusion in the study. A cover letter (see Appendix C) to explain the purpose and focus of the study, a questionnaire, and a self-addressed, stamped envelope were mailed to all adult nurse practitioners, family nurse practitioners, and obstetrical-gynecological nurse practitioners. The return of the questionnaires (see Appendices D and E) indicated willingness to participate. A follow-up postcard (see Appendix F) was sent 7 days later as a reminder to complete the questionnaires. One month was allowed for return of the questionnaires. Data were collected from May 9, 1991, to June 9, 1991.

Methods of Data Analysis

Data to be examined in this study were prepared for coding using the fixed format. Descriptive statistics were used to analyze and synthesize the data in this study. Percentages, frequency distribution, and modes were used to assess the agreement or disagreement to euthanasia across the sample. The section for comments on each question was transcribed and carefully analyzed by a panel of experts for clusters of themes related to attitudes toward geriatric euthanasia. Once themes were identified, they were coded and counted for frequency.

Chapter IV

The Findings

The purpose of this descriptive study was to determine nurse practitioners' attitudes toward geriatric euthanasia. Data were collected using a survey method in which two questionnaires were completed. One questionnaire solicited demographic data while the other questionnaire presented four vignettes describing geriatric patients which required a decision to either endorse or not endorse passive euthanasia.

Description of Sample

The sample included 47 respondents. The age range of subjects was 25 to 55 years of age. The majority, n = 19 (38%), were 35 to 45 years of age, 15 (32%) were aged 25 to 35 years, 13 (28%) were 45 to 55 years, and 1 was over 55 years of age. Forty-one (87%) were female and 4 (9%) were male and 2 did not identify sex. The religious affiliation of the respondents was predominantly Protestant, 35 (75%).

Of the 47 respondents, 4 (9%) were adult nurse practitioners, 25 (53%) were family nurse practitioners, 7 (15%) were obstetrical-gynecological nurse practitioners, 4 (9%) identified themselves only as certified registered

nurse, and 7 (15%) did not designate their area of certification.

The subjects worked primarily in physician clinics with 13 (38%) practicing in collaboration with a physician in the office, 2 (4%) working in a nursing home, 7 (15%) affiliating through the health department, 24 (51%) functioning in other unspecified areas of practice, and only 1 (2%) practicing in home health.

Death knowledge was examined. Four (8%) specified they had received information on death as an undergraduate, 13 (28%) had content in their curriculum in graduate school, 6 (13%) had both undergraduate and graduate content, and 16 (34%) had continuing education about death. Six (13%) had undergraduate and continuing education courses on death, while 2 (4%) had undergraduate, graduate, and continuing education course work on death issues.

Experience with death was also determined. Twenty-five (53%) reported their practice involved fewer than 12 deaths annually and 14 (30%) had more than 12 deaths annually. Eight (17%) did not respond to the question.

Most of the nurse practitioners were master's prepared, 35 (75%), and 11 (23%) had their certificates. Only 1 (2%) had both certificate and master's preparation.

Results of Data Analysis

Nurse practitioner responses to four vignettes were used to answer the research question, what are nurse

practitioners' attitudes toward geriatric euthanasia? Vignette one presented an elder with Laennec's cirrhosis who was in hepatic coma despite a week of vigorous treatment. This patient represented a negative social status. A total of 22 nurse practitioner respondents agreed with the physician's decision and supported passive euthanasia, while 25 respondents disagreed with the physician and endorsed pro-life efforts (see Figure 1).

Vignette two presented an elder who suffered a cardiac arrest. The patient was resuscitated, but he needed to be maintained on a ventilator. This patient represented a positive social status. A total of 17 nurse practitioner respondents agreed with the physician and endorsed pro-life efforts while 30 respondents disagreed with the medical doctor and supported passive euthanasia (see Figure 1).

Vignette three presented an elder who had been in a nursing home and had a diagnosis of senile dementia. The patient was admitted with pneumonia and was successfully treated, but he developed renal failure. This patient represented a negative social status. A total of 26 agreed with the physician and endorsed pro-life efforts, while 21 respondents disagreed with the physician and endorsed passive euthanasia (see Figure 1).

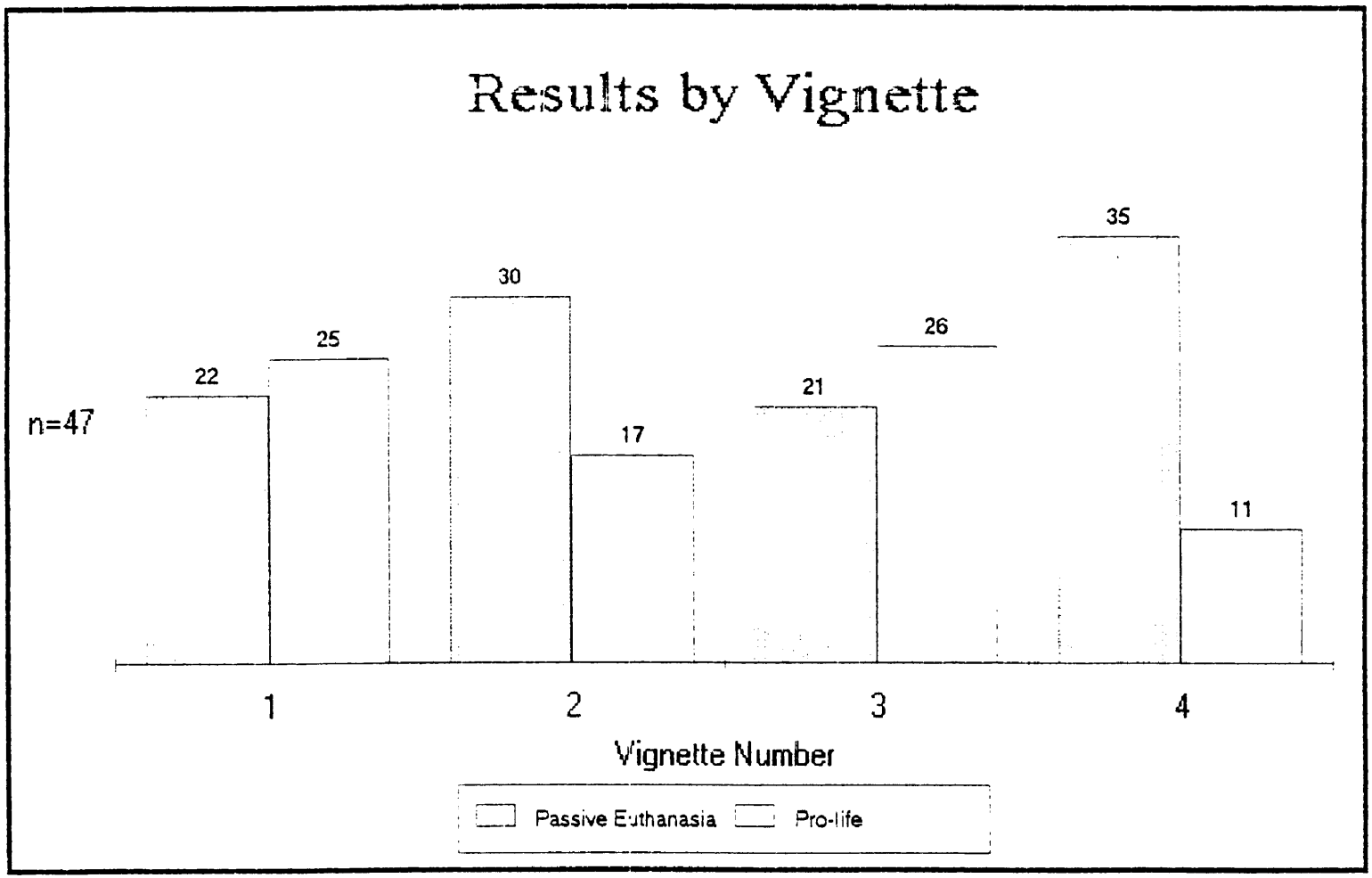

Figure 1. Results by vignette.

Vignette four presented an elder with acute myelogenous leukemia. The patient had experienced three periods of remission but now had experienced pain and increased intracranial pressure due to bleeding in the brain. In this situation, 35 nurse practitioners agreed with the physician and supported passive euthanasia, while 11 disagreed with the physician and endorsed pro-life efforts. One nurse practitioner did not respond (see Figure 1).

In general, when presented with vignettes relevant to passive euthanasia choices for elderly patients, nurse practitioners' attitudes were almost equally divided between pro-life and passive euthanasia decisions. Results of the four vignettes indicated that of the 187 responses to passive euthanasia/pro-life issue, 108 (58%) of the nurse practitioners' choices endorsed passive euthanasia for the elder patient, while 79 (42%) of the nurse practitioners' choices endorsed pro-life for the elder patient (see Figure 2).

Other Findings

Since the comment section was added to the Thompson Life-Prolonging Survey, additional data was obtained which amplified answers to the questions. An open-coding method was used to determine common themes. Six themes emerged including patient/family wishes, poor quality of life, sanctity of life, death with dignity, scarce resources, and ethics.

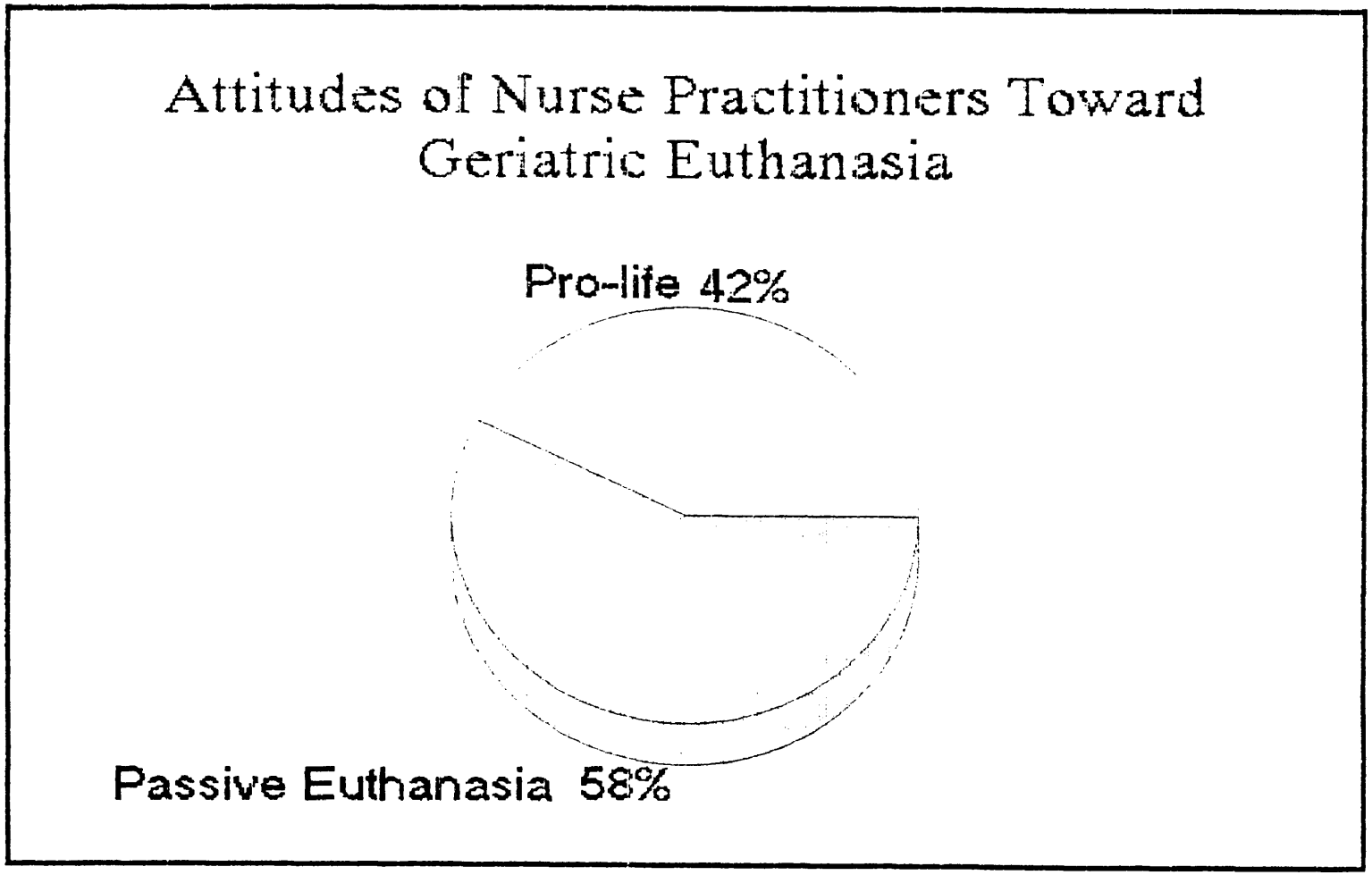

Figure 2. Attitudes of nurse practitioners toward geriatric euthanasia.

The overwhelming theme of patient/family wishes permeated the comment section. Examples of responses that determined this theme include the following quotes: "The family should be consulted when the patient is unable to perform his own self-care, that is, making the treatment decisions" and "No mention is made concerning the patient or family wishes regarding artificial life support." However, patient's wishes were also inferred. Regarding the patient with Laennec's cirrhosis, one respondent answered, "Why prolong death to someone who wants to die?"

Another common theme which emerged was poor quality of life. This theme is represented in these statements, "If [the patient] is brought out of his coma, what type of future would we have? Could or would he contribute anything to his family or to society or would he be a drain on both?" and "If dialysis restores his quality of life then treatment should continue. Otherwise, discontinue any extreme measures and give quality to his dying."

An additional theme identified was the sanctity of life. Examples of relevant comments included, "All efforts to save life should be done," and "As long as there is a means to prevent death, the staff should attempt all procedures, especially if it is the patient and family's best interest."

However, other nurse practitioners realized the need to allow death with dignity. One respondent stated, "This

patient is being kept alive totally on artificial means. For what purpose? Allow him to die with some dignity . . ." and "[This patient] should be allowed to go in peace." Another was "[Passive euthanasia] is the only rational choice--provide a signified remainder of life and eventual death."

Scarce resources was another theme repeated in answers for agreement to passive euthanasia. A representative statement of this theme included, "This is prolonging death. An idiotic waste of money and resources better spent on primary care."

The ethics of euthanasia emerged as the last theme. Some nurse practitioners believed euthanasia was wrong regardless of circumstances, "I am very much opposed to euthanasia, basically because of my religious belief and the pledge I took upon becoming a nurse" and "Control of bleeding for a patient who is comatose is morally and legally right." A board for ethical decision making was suggested, "A special board should be appointed for decisions like these," and "I think at least one other [physician] or [registered nurse] should be consulted or maybe even a priest."

Morality was not the only ethical issue identified. A few nurse practitioners believed euthanasia was not acceptable due to legal constraints. Comments reflecting this issue include, "[The doctor] should get an official 'Do

Not Resuscitate'" and "The physician is not legally covered."

Summary

The analysis of the data generated in this summary revealed that nurse practitioners were almost equally divided between those who support passive euthanasia and those who endorse pro-life decisions. Six common themes emerged from the comment section: patient/family wishes, poor quality of life, sanctity of life, death with dignity, scarce resources, and ethics of euthanasia.

Chapter V

The Outcomes

An explanation of the findings of this study in relation to the research question are summarized and discussed in this chapter. Conclusions are drawn, implications for nursing examined, and recommendations which evolved from these findings are delineated.

Decisions to withhold or withdraw treatment for patients is being addressed more in medical, ethical, legal, and lay literature; but a scant amount of research has been conducted to determine health care professionals' attitudes toward euthanasia. This descriptive study examined nurse practitioners' attitudes toward geriatric euthanasia in the chronically and terminally ill elder. Data were collected using the Thompson Life-Prolonging Survey. Travelbee's Human-to-Human Relationship Model was the theoretical framework for this study.

Summary of Findings

Ninety nurse practitioners in Mississippi were surveyed using a questionnaire that presented four vignettes in which physicians chose either to sustain or not sustain life. Forty-seven questionnaires (52%) were returned and reviewed.

Nurse practitioners made a total of 187 response decisions to the vignettes which determined attitudes. Of these decisions, 108 (58%) endorsed passive euthanasia, while 79 (42%) supported pro-life. Based on this finding, the researcher concluded that nurse practitioners' attitudes were almost equally divided between pro-life and passive euthanasia decisions.

Discussion

In this study, nurse practitioners' attitudes toward geriatric euthanasia varied with the situation. In two of the vignettes, the nurse practitioner agreed with passive euthanasia, and in the other two the majority endorsed pro-life efforts. Since no research has explored this specific finding about nurse practitioner attitudes, the findings can neither be supported nor refuted.

These findings seem to reflect that these nurse practitioners may be experiencing some inner conflict. They were in agreement with euthanasia decisions when the elder patient was believed to be in a terminal state; however, when the patient did not have a terminal diagnosis, they were reluctant to support passive euthanasia. This supposition may be due to the nurse practitioners' lack of clinical exposure to euthanasia type decisions or to the lack of terminal patients in their case load. Additionally, subjects may not have developed a consistent position about euthanasia because of conflicts felt related to religious

beliefs and personal experience. Religious beliefs could have influenced some respondents to choose a pro-life position while placing others in an ambivalent position regarding euthanasia. Some respondents may have believed that agreement with a passive euthanasia decision was the same as murder or that only an "act of God" can shut down all body systems. Also, personal experience may have impacted subjects' indecisiveness on euthanasia because they realize they also are aging. On the other hand, they may have experienced situations similar to ones presented in the vignette in which elders in a long-term critical health state recovered. This finding is in agreement with those reported by Winget et al. (1977) who concluded that inconsistencies in attitudes toward euthanasia were related to personal beliefs. However, these results contradict a study by Degner (1974) who determined a high percentage of physicians (the only primary care providers of that time) favored euthanasia across all vignettes.

Attitudinal decisions in this study may have been affected by the Thompson Life-Prolonging Survey due to the fact that only elder acute care situations were represented which may have been outside the professional experience or expertise of the sampled nurse practitioners. Subject decisions also may have been biased because patient and family wishes were not included in the vignettes. Additionally, attitudes toward euthanasia were not directly

addressed, but rather inferred from decision responses focused on agreement with decision making.

Role perception is another variable that may have affected nurse practitioners' attitudes toward geriatric euthanasia. Nursing is the profession that provides comfort and support for the patient (Webster, 1988; Travelbee, 1971); however, agreeing to euthanasia may be construed by nurse practitioners as a means of denying this caring role. There are no studies that address these suppositions; however, there were studies that support themes that were isolated in analyzing the comment sections.

In general, nurse practitioners' attitudes toward euthanasia centered around six themes: patient/family wishes, poor quality of life, death with dignity, sanctity of life, scarce resources, and ethics. The theme of patient/family wishes was identified in each vignette by subjects. This finding may indicate that nurse practitioners felt compelled to determine patient/family wishes because of their role as patient advocates. Travelbee (1971) addressed this role and believed that the nurse's role of advocate was an extension of the relationship that exists between the nurse practitioner and the patient. By constantly raising the issue of patient/family wishes, the nurse practitioner is acknowledging the identification of patient/family involvement in assisting the elder patient to cope with and

find meaning in chronic illness, dying and death. This theme also is consistent with findings by Davis and Slater (1989) who determined that nurses wanted to involve the family more in decisions about euthanasia and emphasized the nurse's role of advocate in euthanasia decisions.

Death with dignity and sanctity of life were identified as the two most common themes for endorsing or not supporting life-death decisions. The almost equal division of attitudes for or against passive euthanasia found in this study may be based on these two themes. Nurse practitioners may believe patients deserve a peaceful death with limited intervention; however, nurse practitioners may also believe that life is worth living regardless of manner, cost, or expectations. Again, this finding reflects Travelbee's (1971) concept of advocacy as the nurse practitioners believe that euthanasia may be a means of confronting illness, suffering, and dying. It may also reflect the belief that the nurse practitioner role is to help the patient cope and find meaning in suffering. This finding discredits the results of Stoller's (1980) study. Stoller believed registered nurses felt uneasy caring for patients who were dying and related this finding to the fact that registered nurses' job structure removes them from hands-on care and decision making for the dying patient.

Additional themes which emerged were quality of life and scarce resources. Frequently, nurse practitioners

designated quality of life as a factor in deciding or agreeing to passive euthanasia. These nurse practitioners may believe that health care is a commodity that needs to be allocated to the most deserving. In addition, they may believe that health care is an individual's right but may not be practical and/or cost effective for every individual. These findings are supported by Wetle et al. (1988) who concluded these same considerations were instrumental in agreement to withhold therapy (passive euthanasia).

Several nurse practitioners in this study commented about euthanasia as an ethical dilemma and recommended the establishment of a board to help patients make decisions relevant to death and dying issues. This finding is supported by a study conducted by Brown et al. (1971) in which nurses agreed that there was a need for the establishment of a health board to help make life-death decisions.

Conclusions

Several conclusions can be derived from the findings in this study. The primary conclusion is that nurse practitioners' attitudes about euthanasia in the elder patient have not been clearly identified. In this study, an almost equal number chose pro-life decisions and passive euthanasia for geriatric patients. This conclusion may be a consequence of personal experience, religious beliefs, role perceptions, and professional expertise.

Also noted is the fact that the percentage of respondents who agreed to euthanasia (58%) was not exceptionally high. This finding indicates that euthanasia is still a controversial issue and that there is no predominant attitude toward geriatric euthanasia. Attitudes did emerge which favored the sanctity of life and endorsed life as worth living regardless of cost or quality of life. Other attitudes supported death with dignity and viewed death as a natural end to life and that individuals who are dying should be allowed to have control over their manner of dying.

In this study, a large number of respondents specified the need to determine patient/family wishes. The lack of inclusion of this variable in the Thompson Life-Prolonging Survey could have affected subject's responses to the vignettes. Alluding to patient/family wishes may indicate that nurse practitioners are accepting the role of patient advocate and are willing to stand by patients in their decision making.

Implications

The results of this study had implications for nursing. There was a large percentage of respondents who participated in this study which may imply that nurses are interested in developing a position related to euthanasia and that nursing as a profession needs to address the problems involved with euthanasia. Euthanasia has become a health care dilemma

because of the development of technology, the aging of the population, the increasing cost of medical care, and ethical considerations. Education about all the issues surrounding euthanasia will help nursing professionals, patients, and family members or significant others to develop informed attitudes toward geriatric euthanasia.

Another educational implication is the need for schools of nursing to expand personal experiences to include ethical decision-making skills for student nurse practitioners to help solidify their attitudes toward euthanasia. Inclusion of instruction related to the uniqueness of the geriatric client also may help nurse practitioner students become aware of elder problems. In recognizing the specific needs of the elder and in developing better decision-making skills, nurse practitioners would then be more willing to act as advocates on behalf of the elder.

Education is not the only means for the nursing profession to address the problems involved with euthanasia. The nursing profession also could develop alternatives to euthanasia in the acute care setting, such as extended care facilities and hospices. The role of the nurse practitioner could be promoted to include such areas.

Recommendations

Based on the findings of this study, the following recommendations are made:

1. Replication of a similar study to evaluate nurse practitioners' attitudes toward geriatric euthanasia.

2. Education of nurse practitioners and individuals about euthanasia, death, and decision-making skills and ethics.

3. Utilization of the nurse practitioner in alternative care areas such as extended care facilities and hospice.

4. Emphasis on geriatrics in the education of nurse practitioners.

5. Development of a questionnaire which includes the patient/family as a part of ethical decision making in a variety of settings.

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APPENDICES

APPENDIX A

PERMISSION TO USE TOOL

I give my permission to Carol Thompson to use my instrument, the Degner Life Prolonging Scale.

_____

Lesley Degner, PhD

APPENDIX B

APPROVAL OF COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION

MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Vice President for Academic Affairs
P.O. Box W-1603
(601) 329-7142

March 21, 1991

Ms. Carol Thompson
c/o Graduate Nursing Program
Campus

Dear Ms. Thompson:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed study on "Nurse Practitioners' Attitudes Toward Geriatric Euthanasia."

I wish you much success in your research.

Sincerely,

Thomas C. Richardson
Vice President
for Academic Affairs

TR:wr

cc: Dr. Blow
Dr. Hill
Dr. Barrar
Dr. Rent

APPENDIX C

COVER LETTER TO PARTICIPANTS

P. O. Box 493
Bay Springs, MS 39422
March 11, 1991

Dear _____,

Contemporary health care is being affected by the constant stream of improving medical technology and the ever-increasing number of elders in the population. By the year 2025, it is expected 20% of the population will be over 65 years of age.

As a result of a larger proportion of elders and because modern technology has made death almost obsolete, health care professionals are facing problems about when and if life should be prolonged. Euthanasia is a concept that has emerged to deal with this dilemma of death and dying.

As a nurse practitioner graduate student at the Mississippi University for Women, I am interested in studying how nurse practitioners feel toward euthanasia.

Enclosed are two simple questionnaires that will help define your attitudes about geriatric euthanasia. Please note that your responses will remain anonymous since no name will appear on the questionnaires. I would appreciate your answers and comments to the questions.

Please return the questionnaires in the enclosed stamped, self-addressed envelop within the next week.

Thank you for your time.

Sincerely,

Carol V. Thompson, RN, BSN

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Please complete the following demographic survey prior to completing the questionnaire:

Age:
- ___ 25-35 years
- ___ 35-45 years
- ___ 45-55 years
- ___ 55-65 years

Sex:
- ___ Male
- ___ Female

Religious Affiliation:
- ___ Catholic
- ___ Protestant
- ___ Jewish
- ___ Other
- ___ None

Field of Employment:
- ___ NNP
- ___ ANP
- ___ RNC
- ___ PNP
- ___ FNP
- ___ Ob-Gyn
- ___ Other

Place of Employment:
- ___ Nursing home
- ___ Health department
- ___ MD clinic
- ___ Home health
- ___ Other

Death knowledge and experience:
- ___ Undergraduate content
- ___ Graduate content
- ___ Continuing Education
- ___ Practice involved < 12 deaths annually
- ___ Practice involved > 12 death s annually

Practitioner Preparation:
- ___ Certificate
- ___ Master's prepared

APPENDIX E

THOMPSON LIFE-PROLONGING SURVEY

Thompson Life-Prolonging Survey

Directions: The following are four situations which physicians may encounter in clinical practice. Given the amount of information each situation provides, please indicate your degree of agreement or disagreement with the imaginary physicians' decisions by circling one of the four possible responses. Also following each situation is a comments section; please discuss the reasons behind your decision.

SITUATION #1: Mr. S. is a 64-year-old man with Laennec's cirrhosis. The patient is well known to the staff for his frequent admissions to the hospital in pre-hepatic coma, which invariably follow a drunken spree. At present hospitalization, the patient is in hepatic coma, and despite one week of vigorous medical treatment, the coma persists. During the night, the patient begins to bleed from his esophageal varices, and his blood pressure begins to fall. The intern leaves orders for blood replacement and the application of an intra-esophageal device to control bleeding. By the following morning, the patient's bleeding has stopped and remains stopped when the device is removed, but the patient remains in a coma. The attending physician instructs his house staff that if the patient begins to bleed again, they are not to attempt to stop the bleeding.

Would you	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY AGREE

with the attending physician's decision?

Please comment:

_____

_____

_____

_____

_____

SITUATION #2: Mr. M. is a 65-year-old man admitted to hospital with a possible myocardial infarction. The patient is well known to the staff in the coronary care unit, as much for his national prominence as a renowned performer as for his tow previous visits to the unit--the first time after a period of myocardial ischemia, and the second time after a small anterior myocardial infarction. The patient has spent the two years since his recovery from the anterior infarction in the usual pursuit of his career. Twenty-four hours after his admission to the unit, the patient's heart arrests. With much effort on the part of the staff, a spontaneous heart beat is restored, but the patient's respiration must be maintained artificially. The patient remains unconscious. After one week of repeated neurological examinations and flat EEG recordings, physicians consider that brain death has probably occurred. In a conference, the group of physicians decides to maintain the present treatment regimen in the hope that the patient might regain consciousness.

Would you STRONGLY AGREE AGREE DISAGREE STRONGLY AGREE

with the attending physician's decision?

Please comment:

_____

_____

_____

_____

_____

SITUATION #3: Mr. L. is an 85-year-old man with a long time diagnosis of "senile dementia." Prior to his present hospitalization, he had been living in a nursing home for four years. He is admitted to hospital with dehydration and pneumonia. The attending physician prescribes the usual regimen of antibiotics, fluid replacement, chest physiotherapy, etc. The patient's pneumonia begins to respond to these measures, but at the same time he urine output begins to fall. The patient experiences a prolonged period of anuria, such that it is evident to the attending physician that dialysis will be necessary if the patient is to survive the episode of acute renal failure. The physician goes ahead with arrangements for the patient to receive dialysis.

Would you STRONGLY AGREE AGREE DISAGREE STRONGLY AGREE

with the attending physician's decision?

Please comment:

_____

_____

_____

_____

_____

SITUATION #4: Carl is a 76-year-old man with acute myelogenous leukemia. He was first diagnosed 12 months ago, and with chemotherapy has experienced three periods of remission. At his present hospitalization, his physicians have been unable to attain a remission. The patient is very weak and is experiencing severe joint and bone pain. The attending physician notes that the patient's blast cells are extremely high and that there is severe depression of platelet counts. Examination of the patient reveals increased intracranial pressure due to bleeding in the brain. The physician decides to change the treatment regimen, stopping the platelet transfusions and chemotherapeutic drugs, while continuing analgesics and steroid medication.

Would you STRONGLY AGREE AGREE DISAGREE STRONGLY AGREE

with the attending physician's decision?

Please comment:

_____

_____

_____

_____

_____

APPENDIX F

POSTCARD

Dear Nurse Practitioner:

Thank you for helping me with my research project about euthanasia. It is important for all in the advanced nursing role to add to our knowledge about ethical and moral issues. If you have not already completed the questionnaire, please try to do this today. If you have already done this, please disregard this reminder.

Thank you!